		AND HUMAN SERVICES	Ý	pt)	FORM	: 02/02/2011 I APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		155361	B. WING)	01/2	25/2011
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CO	DE.	
AMBER I	MANOR CARE CENT	ER		801 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E STATES SEE	Licensure Survey. Survey dates: January Facility number: 00 Provider number: 1 AIM Number: 1002 Survey Team: Terri Walters RN T Martha Saull RN Elizabeth Harper R 1/18/11, 1/19/11 Carole McDaniel R 1/24/11, 1/25/11 Census Bed Type: SNF: 5 SNF/NF: 51 Total: 56 Census Payor Type Medicare: 8 Medicaid: 26 Other: 22	Recertification and State Jary 18, 19, 21, 24, 25, 2011 0252 55631 67780 C N RECEIVEL FEB 1 7 2011 LONG TERM CARE DIVISION		The submission of the correction does not in admission by the Amb Care Center that the and allegations herein are an accurate representation of the care and services prothe residents of Amb Care Center. This recognized its oblig provide legally and necessary care and sits residents in an and efficient manner. The facility hereby it is in substantial conviction with the requirem participation comprehensive hear facilities (for Title programs).	dicate an or Manor findings contained and true quality of ovided to er Manor facility gation to medically ervices to economic maintains ompliance nents of for lth care	
	accordance with 41 Quality review 1/31 483.13(c)(1)(ii)-(iii), INVESTIGATE/RE ALLEGATIONS/INI	/11 by Suzanne Williams, RN (c)(2) - (4) PORT DIVIDUALS	F 2:	It is thus submitted a of statue only.	re as the on of state and governing is facility.	
ABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE		(X6) DATE
I_{dL}	We July	ctro c	xecut	rie Ducter	- ك	14-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 02/02/2011

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/25/2011	
		155361	B. WING			
	ROVIDER OR SUPPLIER	ĒR	80	EET ADDRESS, CITY, STATE, ZIP CODE 01 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	been found guilty of mistreating resident had a finding enterregistry concerning of residents or mistand report any knot court of law agains indicate unfitness for the facility staff to or licensing authorical transportation of including injuries of misappropriation of immediately to the to other officials in through established State survey and of the facility must have a compresent further potent further p	of employ individuals who have f abusing, neglecting, or the state nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tran employee, which would or service as a nurse aide or of the State nurse aide registry ties. Insure that all alleged violations nent, neglect, or abuse, f unknown source and f resident property are reported administrator of the facility and accordance with State law of procedures (including to the ertification agency). The evidence that all alleged oughly investigated, and must cential abuse while the progress. Insure that all alleged with the ertifications agency and must be reported administrator of the facility and accordance with State law are evidence that all alleged oughly investigated, and must be reported westigations must be reported	F 225	F 225 No residents were affected by alleged deficient practice Completion Date 2-16-201 All residents have the potent affected by the alleged deficient practice therefore through sychanges stated below the cast will ensure the abuse prever policy and procedure is followed to the completion Date 2-16-201 All campus staff has been in regarding investigation proceand requirements of reporting allegations immediately to the Executive Director Completion Date 2-16-201 Systemic change is Campus complete a quarterly in service concerning abuse prevention procedure Completion Date 2-16-201	tial to be itent systematic impus ation owed. I serviced redures ag all he to itee ite	
	by:	and record review, the facility				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 155361 01/25/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST AMBER MANOR CARE CENTER PETERSBURG, IN 47567 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 225 F 225 Continued From page 2 failed to ensure the Administrator was immediately notified of a resident's allegation of a ED/ designee will administer a post staff member acting inappropriately, and failed to test to 2 random campus staff to investigate the incident and report the incident to verify understanding of abuse the state agency, for 1 of 1 resident reviewed for an allegation of abuse in a sample of 14. prevention procedure 5x a week x (Resident #32) one month 3x a week x one month then weekly thereafter with results Findings include: forwarded to the QA committee monthly x 6 months and quarterly Resident #32's clinical record was reviewed on 1/18/11 at 4:12 P.M. Her current Minimum Data thereafter for review and further Set assessment (MDS) dated 12/27/10, indicated suggestions/comments. her cognition was intact. A MDS assessment, **Completion Date 2-16-2011** dated 5/11/10, indicated no cognitive impairment. A nursing note dated 9/19/10 at 1:15 P.M., indicated, "Res (resident) resting in bed. CNA enters room to speak c (with) Res. roommate, activities enters room behind CNA et (and) Res yells out - 'Hey you' - to activities - 'That girl there picked me up et threw me in bed et twisted my ankle.' Res crying @ this time. Res. nurse had just been in c Res. et res was fine et voiced no c/o (complaints)." A nursing note dated 9/19/10 at 1:30 P.M., indicated, "Res resting in bed. No c/o voiced." A nursing note dated 9/19/10 at 1:50 P.M., indicated. "MD notified of the above." On 1/24/11 at 11:30 A.M., the Director of Nursing (DON) was interviewed regarding Resident #32's allegation of abuse documented in the nursing note of 9/19/10. She indicated all the information regarding the allegation was in the nursing note (9/19/10).

PRINTED: 02/02/2011

STATEMENT OF DEFICIENCIES (X1) PROVAND PLAN OF CORRECTION IDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION	COMPLETED	
		155361	B. WING			01/25/2011	
	ROVIDER OR SUPPLIER	ER		80	EET ADDRESS, CITY, STATE, ZIP CODE 11 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	On 1/25/11 at 10:0 interviewed regardithe nurse's note of had not been notification. The facility's abuse "Abuse and Negled reviewed on 1/24/1 included, but was restaff is required to grievances immediexecutive Director Services d. Iden knowledge or suspical report immed 1. ABUSE, NEGLI MISAPPROPRIAT PROPERTY IS A CONTROLL THE LOSS OF PRINURSING ASSISTED The Shift Supervis responsible for init reporting process,	O A.M., the Administrator was ing the allegation of abuse in 9/19/10. She indicated she ed of this allegation. Poolicy (not dated), entitled of Procedural Guidelines," was 1 at 11:00 A.M. This policy not limited to: " Prevention 5. report concerns, incidents, and lately to your manager and/or and Director of Health tification ii. Any person with pension of suspected violations iately, without fear of reprisal. ECT AND ION OF RESIDENT CRIME AND MAY RESULT IN COFESSIONAL LICENSE OR TANT CERTIFICATION. iii. or or Manager is identified as iating and/or continuing the as follows: iv. IMMEDIATELY e Director. If the Executive	F	225			
F 226 SS=D	ABUSE/NEGLECT	F, ETC POLICIES evelop and implement written	F	226			
	policies and proce mistreatment, neg and misappropriat	dures that prohibit lect, and abuse of residents ion of resident property.					

PRINTED: 02/02/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 155361 01/25/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 801 E ILLINOIS ST AMBER MANOR CARE CENTER PETERSBURG, IN 47567 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 226 F 226 Continued From page 4 This REQUIREMENT is not met as evidenced F 226 Based on interview and record review, the facility failed to ensure their abuse prevention policy and No residents were affected by the procedure was implemented, by failing to ensure the Administrator was immediately notified of a alleged deficient practice resident's allegation of a staff member acting Completion Date 2-16-2011 inappropriately and failing to investigate the incident and report the incident to the state All residents have the potential to be agency, for 1 of 1 resident reviewed for an allegation of abuse in a sample of 14. (Resident affected by the alleged deficient #32) practice therefore through systematic changes stated below the campus Findings include: will ensure the abuse prevention policy and procedure is followed. Resident #32's clinical record was reviewed on 1/18/11 at 4:12 P.M. Her current Minimum Data Completion Date 2-16-2011 Set assessment (MDS) dated 12/27/10, indicated

indicated, "Res resting in bed. No c/o voiced."

her cognition was intact. A MDS assessment, dated 5/11/10, indicated no cognitive impairment.

indicated, "Res (resident) resting in bed. CNA enters room to speak c (with) Res. roommate,

activities enters room behind CNA et (and) Res

picked me up et threw me in bed et twisted my ankle.' Res crying @ this time. Res. nurse had just been in c Res. et res was fine et voiced no

yells out - 'Hey you' - to activities - 'That girl there

A nursing note dated 9/19/10 at 1:15 P.M.,

A nursing note dated 9/19/10 at 1:50 P.M., indicated, "MD notified of the above."

A nursing note dated 9/19/10 at 1:30 P.M.,

On 1/24/11 at 11:30 A.M., the Director of Nursing (DON) was interviewed regarding Resident #32's

All campus staff has been in serviced regarding investigation procedures

and requirements of reporting all

allegations immediately to the

Executive Director

procedure

Completion Date 2-16-2011

c/o (complaints)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		·	(X3) DATE SURVEY COMPLETED		
		155361	B. WIN	G		01/2	01/25/2011	
	ROVIDER OR SUPPLIER	ER		80	ET ADDRESS, CITY, STATE, ZIP CODE 1 E ILLINOIS ST ETERSBURG, IN 47567			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 226	allegation of abuse note of 9/19/10. Si regarding the alleg (9/19/10). On 1/25/11 at 10:0 interviewed regard the nurse's note of had not been notifit. The facility's abuse "Abuse and Negler reviewed on 1/24/" included, but was staff is required to grievances immed Executive Director Services d. Idenknowledge or susphall report immed 1. ABUSE, NEGL MISAPPROPRIAT PROPERTY IS A THE LOSS OF T	e documented in the nursing the indicated all the information ation was in the nursing note allow the nursing note allowed the allegation of abuse in 9/19/10. She indicated she allegation. The policy (not dated), entitled at Procedural Guidelines," was at at 11:00 A.M. This policy not limited to: " Prevention 5. report concerns, incidents, and liately to your manager and/or and Director of Health atification ii. Any person with bension of suspected violations liately, without fear of reprisal. ECT AND TON OF RESIDENT CRIME AND MAY RESULT IN ROFESSIONAL LICENSE OR TANT CERTIFICATION. iii. For or Manager is identified as diating and/or continuing the as follows: iv. IMMEDIATELY the Director. If the Executive they may appoint a		226	ED/ designee will administer test to 2 random campus starverify understanding of abus prevention procedure 5x a wone month 3x a week x one then weekly thereafter with forwarded to the QA commismonthly x 6 months and quathereafter for review and fur suggestions/comments. Completion Date 2-16-201	ff to se veek x month results ttee urterly ther		
F 250 SS=D	483.15(g)(1) PRO RELATED SOCIA The facility must p services to attain of	VISION OF MEDICALLY L SERVICE rovide medically-related social or maintain the highest al, mental, and psychosocial	F	250				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION		COMPLETED	
	155361	B. WIN	G		01/25	5/2011	
NAME OF PROVIDER OR SUPPLIER AMBER MANOR CARE CENT	ER		80	EET ADDRESS, CITY, STATE, ZIP CODE 1 E ILLINOIS ST ETERSBURG, IN 47567	E		
PREELY (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 250 Continued From pa well-being of each	- ·	F2	250	F 250			
by: Based on observareview, the facility behaviors and psy documented, mon residents reviewed psychosocial sympates and psychosocial sympates and psychosocial sympates and psychosocial sympates and psychosocial recovered on 1/18/included, but were dementia with behavior psychosis. The modern of the following for the score was zero, wo cognitive impairmed were identified as A psychiatric evaluation of the following: Diagram of the	tion, interview and record failed to ensure observed chosocial needs were stored and addressed, for 1 of 3 with behaviors and/or otoms in a sample of 14. ord of Resident #14 was 11 at 3:10 P.M. Diagnoses not limited to, the following: avioral disturbances and nost recent MDS (Minimum tent) dated 12/31/10, indicated e resident: cognitive summary hich indicated a severe ent; symptoms present of mood "no response." uation, dated 9/11/10, indicated gnoses: "beh (behavioral) hosisanxiety/dep derinitial treatment plan: (antipsychotic medication) to 5 by)c/o (complaints of): edical floor after she received She originally came from nome) through the ER (for low is cresident) very paranoid, s: depressed, crying, lack of tatus exam: depressed and			Resident #14 no longer recampus. Completion Date 2-16-2 All residents have the potaffected by the alleged depractice and therefore threalterations in processes as servicing the campus will provides medically-relate services to attain or mainthighest practicable physicand psychosocial well-being resident. Completion Date 2-16-2 All campus staff has been on appropriate response to behavior and required docof that behavior. Campus have been in serviced on a new assessment titled Mellness Circumstance, A and Intervention form when an exacerbation of a behavior Date 2-16-20 Completion Date 2-16-20	tential to be efficient ough and in lensure it and social tain the cal, mental, ing of each of the control of t		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

AND BLANDE CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
	155361	B. WING	01/25/2011	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST

AND THE STATE OF T		801 E ILLINOIS ST				
AMBER MANOR CARE CENTER		PETERSBURG, IN 47567				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 250 Continued From page 7	F 250	· ·				
Scared" A behavorial health progress note, dated 9/15/10, included, but was not limited to, the following: "Mood: OK" (depressed was an option but was not checked). A "Hospice" plan of care was dated 12/10/10. Interventions included, but were not limited to, the following: "Allow resident to discuss painful feelings if able. Do not deny death if resident wants to talk about it." Nurses notes, dated 12/28/10 (sic), at 2300 (11 P.M.), indicated the following: "Res (resident) very tearful saying 'I want to go home.' All attempts made to comfort res refusedHospice nurse updated on res condition et (and) tearfulness at this tx (time). Hospice nurse stated she would see res in AM (morning) et (and) contact Dr. (physician name) with update." Nurses notes, dated 12/28/10 at 0946 (9:46 A.M.), indicated the following: "Res. cont. (continue) with hospice care services. Res. has been very tearful. Res. has not wanted to eat" Hospice nurses notes, dated 12/30/10, included, but were not limited to, the following: "tearful at times, tearful, wants to go home" Hospice nurse notes, dated 1/6/11, included, but were not limited to, the following: "has been very tearful, to be seen by house psyc (psychiatrist) for recommend (recommendations) for depression." Nurses notes, dated 1/7/11 at 0630 (6:30 A.M.): "Res continues with Hospice care. Res. Was		Systemic change will include completing the Mental Health Wellness Circumstance, Assessment, and Intervention form when a new or an exacerbation of a behavior occurs. Completion Date 2-16-2011 SSD and /or designee will print group behavior detail report daily to assure the Mental Health Wellness Circumstance, Assessment, and Intervention form was completed when indicated to assure behaviors and psychosocial needs were documented, monitored, and addressed. Results of daily audits will be forwarded monthly to QA for 6 months and quarterly thereafter for further suggestion/recommendations based on compliance. Completion Date 2-16-2011				

PRINTED: 02/02/2011

NAME OF PROVIDER OR SUPPLIER AMBER MANOR CARE CENTER (A) ID (SLOW MARY STATEMENT OF DEFICIENCIES PRETERBURG, IN 47657 PRETEX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S. IDENTIFYING INFORMATION) F 250 Continued From page 8 crying and stating "I want to go home"Res began crying again after drink was gone. Res with staff one on one for comforting. Res began to cry harder while taking to staff" Nurses notes, dated 1/10/11 at 0330 (3:30 A.M.): "res remains learful, frequently stating "Please Lord, take me home"unable to determine cause for tears Hospice kept advisedDr. (physician name) updated." Hospica nurse notes, dated 1/12/11, included, but were not limited to, the following: "Started on Zoloft 25 mg qd (every day), started on 1/10/11" On 1/19/11, the resident's care was monitored from 8:50 A.M. until 2:30 P.M. At 10:00 A.M., CNA #7 and CNA #8 were observed to assist the resident in her bed. The resident was crying and stated, "lear me, I want to die. CNA #7 stated, "You're OK." The resident continued to cry and stated, "Can't do nothing right anymore. I just want to die." CNA #8 stated "Oh, honey." The resident then stated, "I don't know how I got in such a mess." Neither CNA responded. At 10:05 A.M., the resident was repeating "I want to die. I want to die. Ch please Cod, help me." CNA #7 stated as she worked "We're here for you." The resident began repeating, "I can't stand it." CNA #8 stated, "I can't handle it." Neither CNA responded verbally as they assisted the resident to get out of bed.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER AMBER MANOR CARE CENTER (X4.10) SUMMARY STATEMENT OF DEFICIENCES (CAL10) GLOCK DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F250 Continued From page 8 crying and stating "I want to go home"Res began crying again after drink was gone. Res with staff one on one for comforting. Res began to cry harder while talking to staff" Nurses notes, dated 1/10/11 at 0330 (3:30 A.M.): "res remains tearful, frequently stating "Please Lord, take me home"unable to determine cause for tearsHospice kept advisedDr. (physician name) updated." Hospice nurse notes, dated 1/12/11, included, but were not limited to, the following: "Started on Zoloft 25 mg qd (every day), started on 1/10/11" On 1/19/11, the resident's care was monitored from 8:50 A.M. until 2:30 P.M. At 10:00 A.M., CNA #7 and CNA #8 were observed to assist the resident in her bed. The resident was crying and stated, "I can't do nothing right anymore. I just want to die," CNA #8 stated "Oh, honey." The resident then stated, "I don't know how! go in such a mess." Neither CNA responded. At 10:05 A.M., the resident was straing, "Oh God, take me home.! want to die. I can't handle it." Neither CNA responded werehold yes the was stated. At 10:07 A.M., the resident was stating, "Oh God, take me home.! I want to die. I can't handle it." Neither CNA responded werehold was stisted.			155361	B. WII	B. WING		01/25/2011		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 250 Continued From page 8 crying and stating "I want to go home"Res began crying again after drink was gone. Res with staff one on one for comforting. Res began to cry harder while talking to staff" Nurses notes, dated 1/10/11 at 0330 (3:30 A.M.): "res remains tearful, frequently stating "Please Lord, take me homeunable to determine cause for tearsHospice kept advisedDr. (physician name) updated." Hospice nurse notes, dated 1/12/11, included, but were not limited to, the following: "Started on Zoloft 25 mg qd (every day), started on 1/10/11" On 1/19/11, the resident's care was monitored from 8:50 A.M. until 2:30 P.M. At 10:00 A.M., CNA #7 and CNA #8 were observed to assist the resident in her bed. The resident touritnued to cry and stated, "Help me, I want to die." CNA #7 stated, "You're OK." The resident continued to cry and stated, "I'can't do nothing right anymore. I just want to die." CNA #7 stated "I don't know how I got in such a mess." Neither CNA responded. At 10:05 A.M., the resident was repeating "I want to die, I want to die, Oh please God, help me." CNA #7 stated as she worked "We're here for you." The resident began repeating, "I can't stand it." CNA #8 stated, "oh." At 10:07 A.M., the resident was stating, "Oh God, take me home. I want to die. I can't and to die. I can't than die it." Neither CNA responded.			ER	,_ _	80	01 E ILLINOIS ST		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
crying and stating 'I want to go home'Res began crying again after drink was gone. Res with staff one on one for comforting. Res began to cry harder while talking to staff" Nurses notes, dated 1/10/11 at 0330 (3:30 A.M.): "res remains tearful, frequently stating 'Please Lord, take me home'unable to determine cause for tearsHospice kept advisedDr. (physician name) updated." Hospice nurse notes, dated 1/12/11, included, but were not limited to, the following: "Started on Zoloft 25 mg qd (every day), started on 1/10/11" On 1/19/11, the resident's care was monitored from 8:50 A.M. until 2:30 P.M. At 10:00 A.M., CNA #7 and CNA #8 were observed to assist the resident in her bed. The resident was crying and stated, "Help me, I want to die." CNA #7 stated, "You're OK." The resident continued to cry and stated, "I can't do nothing right anymore. I just want to die." CNA #8 stated "Oh, honey." The resident then stated, "I don't know how I got in such a mess." Neither CNA responded. At 10:05 A.M., the resident was repeating "I want to die, I want to die, Oh please God, help me." CNA #7 stated as she worked "We're here for you." The resident began repeating, "I can't stand it." CNA #8 stated, "oh." At 10:07 A.M., the resident was stating, "Oh God, take me home. I want to die, Lan't handle it." Neither CNA responded verbally as they assisted	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOORS-REFERENCED TO THE APP	OULD BE	COMPLETION	
At 10:10 A.M., the resident was sitting on the side	F 250	crying and stating 'I crying again after done on one for comharder while talking. Nurses notes, date "res remains tear Lord, take me hom for tearsHospice name) updated." Hospice nurse note were not limited to, Zoloft 25 mg qd (ev 1/10/11" On 1/19/11, the res from 8:50 A.M. untic CNA #7 and CNA #7 resident in her bed stated, "Help me, I "You're OK." The stated, "I can't do nowant to die." CNA resident then stated such a mess." Ne At 10:05 A.M., the I to die, I want to die CNA #7 stated as syou." The resident stand it." CNA #8 At 10:07 A.M., the I take me home. I we Neither CNA response to get of the resident to get of the stated and the resident to get of the residen	I want to go home'Res began rink was gone. Res with staff aforting. Res began to cry to staff" d 1/10/11 at 0330 (3:30 A.M.): ful, frequently stating 'Please e'unable to determine cause kept advisedDr. (physician es, dated 1/12/11, included, but the following: "Started on very day), started on very day), started on very day), started on very day, started on want to die." CNA #7 stated, resident continued to cry and want to die." CNA #7 stated, resident continued to cry and want to die." CNA #7 stated, resident continued to cry and want to die." CNA #7 stated, resident continued to cry and want to die." CNA responded. #8 stated "Oh, honey." The d, "I don't know how I got in ither CNA responded. resident was repeating "I want. Oh please God, help me." she worked "We're here for the began repeating, "I can't stated, "oh." resident was stating, "Oh God, want to die. I can't handle it." anded verbally as they assisted out of bed.	F	250				

PRINTED: 02/02/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	·	155361	B. WING		01/2	25/2011	
	ROVIDER OR SUPPLIER		801	ET ADDRESS, CITY, STATE, ZIF E ILLINOIS ST TERSBURG, IN 47567	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 250	of her bed with Cl The resident state throw everything a don't want to do th "I'd rather die that responded. On 1/21/11 at 10: observed to be in room during an a residents. The re wanna die." The staff. The resident wanna die." Acti don't," as she wan On 1/21/11 at 9:3 social service not coordinator. The "9/2/10:Emen9/5/10: Reside and expressing p calling 911 for poi intake and state to Reported per nur room mate's belo thoughtsDrco inpatient behavior ResidenttoBe treatment9/15/readmittedfromresident was re frombehavioral treated for psychi and alz (Alzheime The most recent 12/17/10 and inci	NA #7 and CNA #8 assisting. ed, "Please God, help me. Just away." CNA #8 stated, "We hat." The resident then stated, n anything." Neither CNA 55 A.M., the resident was her wheelchair in the activity ctivity with activity staff and other esident stated, "I wanna die, I wity Staff #1 stated, "No you liked by the resident. 60 A.M., copies of the resident's lies were received from the MDS see notes indicated the following: gency admitted (sic) from home ant is noted to be anxious this day aranoid thoughtstalks of lice. Tearful, refuses lunch that food is poisonous9/8/10: sing staff resident pilfering in lingings and having paranoid antacted with ordersper ral setting9/10/10: shavioral Health for inpatient	F 250				

Facility ID: 000252

PRINTED: 02/02/2011 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		PLE CONSTRUCTION G	COMPLETED		
		155361	B. WII	1G _		01/25	5/2011
	ROVIDER OR SUPPLIER	ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 01 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	hold" On 1/21/11 at 10:4 Nursing) was interdocument the reside (facility computer some of the resident name o	0 A.M., the DON (Director of viewed. She indicated staff dent's behaviors in the KIOSK	F	250			

PRINTED: 02/02/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPL LDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		155361	B. WING			01/25/2011		
	PROVIDER OR SUPPLIER	ER		801	ET ADDRESS, CITY, STATE, ZIP COI 1 E ILLINOIS ST ETERSBURG, IN 47567	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 250	On 1/21/11 at 10:5 KIOSK "Group Bel was reviewed. No the month to date. On 1/24/11 at 1:20 for "Social Assess ADON (Assistant I was undated. The limited to, the follomust be conducteresident's personal significant to the retreatment Assesse evaluation of the functioning to incluself and situation, institutional environs social assessmen social services poplan"	age 11 0 A.M. a copy of the resident's navior Chart" for January 2011 incidents were documented for P.M., a policy and procedure ment" was received from the Director of Nursing). This policy policy included, but was not wing: "A social assessment d to assist in identifying the and social problems esident's course of sment should include an ollowing areas:Psychosocial ide: emotional stance toward: family and others and nmentData obtained from the triust be used to develop the rition of the comprehensive care	F	250				
	September 2010 to categories of this "wandering, wand abuse, verb. Altern phys. Alterable, so (inappropriate), so resist alterable." one incident docu one incident of phonomer of the resident had be Risk) program fro	hrough January 2011. The chart included the following: ering alterable, verb (verbal) able, phys. (physical) abuse, oc (socially) inap. oc inap. Alterable, resists care, For the year 2010, there was mented for physical abuse and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING			COMPLETED 01/25/2011	
	155361						
	NAME OF PROVIDER OR SUPPLIER AMBER MANOR CARE CENTER			801	EET ADDRESS, CITY, STATE, ZIP CODE 1 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ζ	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272 SS=D	behaviors stabilized remained on the Crissues. The DON a resident was restart behaviors on 12/20 recent copy of the 1/20/11. These no resident's weight a of the behaviors as weekly follow up for "Resident's behavior Continue current in continues to exhibit below for updated left unmarked for the Both the Administrative aware of the and/or monitoring. 3.1-34(a) 483.20, 483.20(b)	d, but the resident then AR program due to her weight and Administrator indicated the ted on the CAR program for 1/10. They provided the most resident's CAR notes from tes only addressed the and were lacking documentation to observed on 1/19/11. The or this date indicated, or patterns remain stable. Interventions; and Resident to behavior concerns. See interventions" and were both the 1/20/11 assessment date. ator and DON indicated they lack of behavior documentation	F 2		F 272 Res #14 no longer resides campus. Resident #3 was evaluated therapy and plan was as for resident ambulates indepe	l by ollowed	
	a comprehensive, reproducible asses functional capacity A facility must mak assessment of a respecified by the Strinclude at least the	te a comprehensive esident's needs, using the RAI ate. The assessment must following: temographic information;			with a rolling walker but of to due to her confidence less history of falls. She require encouragement to walk independently or ask for a when she so desires. No fit therapy intervention is independently encouragement was perestorative program. Resident # 41's skin impa from the fall are now heal Completion Date 2-16-20	chooses not evel and es es essistance arther licated at laced on a irments ed	

		4				-	
		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	02/02/2011 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		155361	B. WIN	1G		01/2!	5/2011
	ROVIDER OR SUPPLIER	ER		80	EET ADDRESS, CITY, STATE, ZIP CODE 1 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	Physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia Documentation of the additional asseresident assessme Documentation of This REQUIREME by:	and structural problems; and health conditions; hal status; and procedures; l; summary information regarding ssment performed through the	F	272	All residents have the poter affected by the alleged defi practice and through altered processes and in servicing to campus will ensure accurate assessments. Completion Date 2-16-201 A skin sweep has been prefit the campus on all residents all skin impairments have be accurately identified and as All nurses have been in-ser related to assessment of skin impairment and timely skin impairment and timely skin.	cient ations in the e 11 formed in to assure seen ssessed. viced	

review, the facility failed to accurately assess a blister and/or shearing areas as pressure sores for 1 of 2 residents reviewed for pressure sores in a sample of 14. Resident #14

- B. Based on observation, interview and record review, the facility failed to assess and monitor resident behaviors and/or psychosocial needs for 1 of 3 residents reviewed for behaviors in a sample of 14. Resident #14
- C. Based on observation, record review and interview, the facility failed to assess the ambulation needs of 1 of 1 resident requesting ambulation services from a sample of 14. Resident #3
- D. Based on observation, interview and record review, the facility failed to ensure an accurate

assessments. Nursing staff have been in serviced on using the skin examination reporting tool for timely identification of skin impairments.

All campus staff has been in serviced on appropriate response to a behavior and required documentation of that behavior. Campus nurses have been in serviced on using the new assessment titled Mental Wellness Circumstance, Assessment and Intervention form when a new or an exacerbation of a behavior occurs.

PRINTED: 02/02/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING B. WING 01/25/2011 155361 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 801 E ILLINOIS ST AMBER MANOR CARE CENTER PETERSBURG, IN 47567 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES IΩ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 272 Continued From page 14 F 272 skin assessment was completed promptly after a resident had a fractured right arm for 1 of 1 All residents in the campus with the resident reviewed with a fracture in a sample of ability to ambulate have been 14. Resident #41 screened by therapy to assess ambulation needs. Findings include: Completion Date 2-16-2011 A. The clinical record of Resident #14 was reviewed on 1/18/11 at 3:10 P.M. Diagnoses Systemic changes nursing staff to included, but were not limited to, the following: complete the skin examination anemia, B12 deficiency, muscle weakness, dementia with behavioral disturbance and

Upon entrance into the building, the facility-provided roster sample/matrix, did not indicate this resident had a pressure sore.

incontinent of bowel and bladder.

psychosis. The MDS (minimum data set

assessment) dated 1/3/11, indicated the following

developing pressure sores; bed mobility required extensive assistance (resident involved in activity,

staff provide weight-bearing support); ambulation

in room and corridor didn't occur; resident always

for the resident: cognition summary score was totaled to be zero, which indicated a severely impaired cognition status; was at risk for

An ADL (activities of daily living) care plan, dated 9/15/10, indicated the following: "Needs assistance or is dependent in: bed mobility, transfer...personal hygiene..." The intervention of "turn and reposition, shifting weight to enhance circulation" was left unchecked and not identified as an intervention.

A care plan, which addressed the problem of "potential alteration in skin integrity" was dated 9/15/10. Interventions which were listed as an option, but were left blank and not included, were reporting tool and forward to the nurse to complete assessment of new skin impairment.

Systemic change will include completing the Mental Health Wellness Circumstance, Assessment, and Intervention form when a new or an exacerbation of a behavior occurs.

Systemic change to include therapy to complete quarterly screens for residents with the ability to ambulate to assess ambulation needs and assure needs met.

Completion Date 2-16-2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		155361	B, Wil	1G _		01/25	5/2011
	PROVIDER OR SUPPLIER	ΞR		80	EET ADDRESS, CITY, STATE, ZIP CODE 01 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 272	"turn and reposition Nurses notes, date indicated the follow have a red sheared. A form titled "Other Assessment" was a identified the areas admission; type: slength: 0.3; width 0 recent weekly mean indicated a length of "E." On 1/25/11 at 1 P.M. Nursing) was intervedent indicated. A Pressure Ulcer L. dated 12/27/10. The "Clinical conditions makes the likelihood unavoidable includeresident immobility continuous urinary failure to thrive, high mg/dl (milligrams poskin turgor and reseposition, attempts to without success." A physician order, of following: "Apply slon upper thigh daily On 1/19/11 at 9:30 interviewed. She in	d 12/17/10, at 10 A.M. ing: "R (right) hip noted to I area" Skin Impairment dated 12/17/10. This form as follows: Not present on nearing; Location on right hip: 0.2; depth <0.2 (sic). The most surement was on 1/17/11 and of 1.2; width of 1.3 and depth of M., the DON (Director of riewed. She indicated the "E" yellow drainage. etter of Unavoidability was his form indicated the following: this resident exhibit that d of this pressure ulcer but are not limited to, and: Hospice, no code; incontinence; dementia, adult o (hemoglobin) less than 12 er deciliter), pale skin, poor d (resident) lies in fetal o get resd to lie extended dated 12/29/10, indicated the kin prep to water filled blister of x 7 days" A.M., CNA #8 was adicated the resident "had a ip and they needed to keep	F:	272	DHS/Designee will review the examination reporting tool to accurate and timely assessment skin impairments 5x a week is month 3x a week x one month weekly with results forwarded QA committee monthly x 6 mand quarterly thereafter for reand further suggestions/commissions behavior detail report assure the Mental Health Wester Circumstance, Assessment, a Intervention form was composed when indicated to assure behand psychosocial needs were documented, monitored, and addressed. Results of daily audits will be forwarded monthly to QA formonths and quarterly thereafter further suggestion/recomments are followed to meet the resistant and the property of the property o	o assure ent of x one h then of to the months eview ments. int daily to ellness and leted aviors ent of fter for ndations ew lations idents ts being ittee arterly ther	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE		
		155361	B. WIN	IG		01/2	5/2011	
	ROVIDER OR SUPPLIER	ER		80	EET ADDRESS, CITY, STATE, ZIP CODE 01 E ILLINOIS ST ETERSBURG, IN 47567			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 272	I .	e was observed on 1/19/11. At	F	272				
	10 A.M., CNA #7 a assisting the reside brief. With the resident was rolled began rolling up the brief, until the roller resident's skin. CN the resident's left his she pulled the brief ight hip, which was brief was removed the brief was stretcoreating a shearing	and CNA #8 were observed ent to check and change her ident on her back, they in both sides of the brief. The to her right side. CNA #7 then e left side of the resident's d brief was close to the NA #7 then applied pressure to hip and with CNA #7's hand, fout from under the resident's s planted on the bed. As the from underneath the resident, ched taught upon removal, g effect. A dressing was sident's right hip dated 1/19/11.						
	the resident by che Again, the CNAs a observed at 10 A.M the resident's brief to the resident's sk pressure to the res #7's hand, she pull resident's right hip As the brief was re	and CNA #8 again assisted ecking and changing her brief. assisted the resident as M. by rolling up the left side of until the rolled brief was close in. CNA #7 then applied sident's left hip and with CNA led the brief out from under the which was planted on the bed. Emoved from underneath the was stretched taught upon a shearing effect.						
	Nursing) was inter open area on the r of shearing from the On 1/24/11 at 3:20	O A.M., the DON (Director of viewed. She indicated the resident's right hip was a result ne brief. O P.M., the DON provided a opy of the facility's policy and						

•	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		155361	B. WII	NG_		01/2	5/2011
	OVIDER OR SUPPLIER	ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΊX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	was not limited to, to as definedas a rewith shear and frict be classified by design damage observed; blister" Documentation was assessment to ider areas as being present as being present as a being present as being present as a being	ion." This policy included, but the following: "Pressure ulcers sault of pressure in combination ion. Pressure wounds should scribing the degree of tissue Stage II:may present as a slacking of an accurate ntify the blister and shearing ssure sores. ord of Resident #14 was 1 at 3:10 P.M. Diagnoses not limited to, the following: avioral disturbances and ost recent MDS (Minimum ent) dated 12/31/10, indicated a resident: cognitive summary nich indicated a severe ent; symptoms present of mood	F	272			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	LDIN		COMPLET	
		155361	B. WIN	IG_		01/25	/2011
	ROVIDER OR SUPPLIER	ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 01 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTT CROSS-REFERENCED TO THE APPROPRIEM (ENCY)	ULD BE	(X5) COMPLETION DATE
F 272	"Mood: OK" (deprinot checked). A "Hospice" plan of Interventions included following: "Allow refeelings if able. Downts to talk about the Nurses notes, date P.M.), indicated the very tearful saying attempts made to nurse updated on tearfulness at this she would see rescontact Dr. (physic Nurses notes, date A.M.), indicated the (continue) with hospice nurses not limited times, tearful, wan Hospice nurse not limited times, tearful, to be (psychiatrist) for refor depression." Nurses notes, date "Res continues wir crying and stating crying again after the solution of the plant of the property in the plant of the property in the plant of	f care was dated 12/10/10. ded, but were not limited to, the esident to discuss painful o not deny death if resident it." ded 12/28/10 (sic), at 2300 (11 de following: "Res (resident) '! want to go home.' All comfort res refusedHospice res condition et (and) tx (time). Hospice nurse stated in AM (morning) et (and) dian name) with update." ded 12/28/10 at 0946 (9:46 de following: "Res. cont. spice care services. Res. has Res. has not wanted to eat" detes, dated 12/30/10, included, dto, the following: "tearful at the togo home" des, dated 1/6/11, included, but the following: "has been seen by house psychecommend (recommendations) ded 1/7/11 at 0630 (6:30 A.M.): the Hospice care. Res. Was '! want to go home'Res begand drink was gone. Res with staff mforting. Res began to cry		272			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		155361	B. WIN	IG _		01/25/2011	
	ROVIDER OR SUPPLIER	ER	•	8	REET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ıge 19	F	272			
	"res remains tear Lord, take me hom for tearsHospice name) updated."	d 1/10/11 at 0330 (3:30 A.M.): ful, frequently stating 'Please e'unable to determine cause kept advisedDr. (physician es, dated 1/12/11, included, but					
		the following: "Started on very day), started on					
	from 8:50 A.M. unti CNA #7 and CNA # resident in her bed stated, "Help me, I "You're OK." The stated, "I can't do n want to die." CNA resident then state	sident's care was monitored il 2:30 P.M. At 10:00 A.M., #8 were observed to assist the . The resident was crying and want to die." CNA #7 stated, resident continued to cry and nothing right anymore. I just a #8 stated "Oh, honey." The d, "I don't know how I got in either CNA responded.					
	to die, I want to die CNA #7 stated as s	resident was repeating "I want . Oh please God, help me." she worked "We're here for t began repeating, "I can't stated, "oh."					
	take me home. I w	resident was stating, "Oh God, vant to die. I can't handle it." onded verbally as they assisted out of bed.					
	of her bed with CN. The resident stated throw everything as	resident was sitting on the side A #7 and CNA #8 assisting. d, "Please God, help me. Just way." CNA #8 stated, "We at." The resident then stated,					

PRINTED: 02/02/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	COMPLETED		
		155361	B. WI	₩G		01/2	5/2011
	ROVIDER OR SUPPLIER	ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 01 E ILLINOIS ST PETERSBURG, IN 47567	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 272	"I'd rather die than responded. On 1/21/11 at 9:30 social service note coordinator. Thes "9/2/10:Emerg9/5/10: Residen and expressing parcalling 911 for poli intake and state the Reported per nurs room mate's below thoughtsDrcom inpatient behavioral ResidenttoBeh treatment9/15/10 readmittedfromresident was reafrombehavioral intreated for psycholand alz (Alzheimer The most recent sold 12/17/10 and inclus following: "order hold" On 1/21/11 at 10:4 Nursing) was interesident the resident "not hold"	anything." Neither CNA A.M., copies of the resident's sewere received from the MDS enotes indicated the following: ency admitted (sic) from home to is noted to be anxious this day ranoid thoughtstalks of ce. Tearful, refuses lunch at food is poisonous9/8/10: ing staff resident pilfering in agings and having paranoid atacted with ordersper al setting9/10/10: avioral Health for inpatient D: Residentbehavioral health9/22/10: admitted on 9/15/10 health where she had been sis, behavioral disturbances r) type dementia" ocial service note was dated aded, but was not limited to, the received to place Zyprexia on 40 A.M., the DON (Director of viewed. She indicated staff dent's behaviors in the KIOSK	F	272			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 000252

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPLE	
		155361	B. WING		01/2	5/2011
	ROVIDER OR SUPPLIER	ER	80	ET ADDRESS, CITY, STATE, ZIP CODE 1 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	On 1/24/11 at 1:30 interviewed. She i monitoring the resi CNAs (certified nu the resident's beha KIOSK. The SSD admitted to the beson at the second to the second the	P.M., the SSD was ndicated the "first trigger" to ident's behaviors would be the rsing assistants) would indicate aviors by entering them on the indicated the resident was cility on 9/2/10 and was havior unit from 9/10 to 9/15/10. If the resident did not have any ented in the KIOSK for the year edicated the reason the resident chavior unit was due to so paranoid thoughts and was ated the resident's behaviors tracked if the CNAs put them in its D indicated she "knew and the behaviors, because I yeelf." She indicated the main aware of the resident's the KIOSK. She indicated she are of resident behaviors through the staff telling her of incidents. In the building and behaviors in the KIOSK, she led of the behavior.	F 272			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		155361	B. WI	√G		01/2	5/2011
	ROVIDER OR SUPPLIER	ER		80	EET ADDRESS, CITY, STATE, ZIP CODE D1 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	treatmentAssessive audition of the formationing to include self and situation, finstitutional environs social assessment social services portion plan" On 1/24/11 at 2:30 Behavior Chart" from September 2010 the categories of this community wandering, wandering incident document one incident document one incident document incident of phy On 1/25/11 at 10 A Administrator were the resident had be Risk) program from behaviors. They in behaviors stabilized remained on the Chissues. The DON aresident was restar behaviors on 12/29 recent copy of the in 1/20/11. These not resident's weight at of the behaviors as weekly follow up fo "Resident's behavior Continue current in	ment should include an llowing areas:Psychosocial de: emotional stance toward: amily and others and mentData obtained from the must be used to develop the tion of the comprehensive care P.M., the resident's "Group of the KIOSK was reviewed for grough January 2011. The hart included the following: ring alterable, verb (verbal) ble, phys. (physical) abuse, co (socially) inap. It inap. Alterable, resists care, for the year 2010, there was nented for physical abuse and stalterable.	F	272			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU		NG	COMPLE	
		155361	B. Wil	1G _		01/2	5/2011
	ROVIDER OR SUPPLIER	ER	<u> </u>	٤	REET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 272	below for updated left unmarked for the Both the Administration was read and/or monitoring. Documentation was the resident's psychastrelated to her described and reliable Resident #3 was in P.M. The resident staff) are supposed twice a day but the they got a belt (gain don't get it done. I time ran out. I was don't get the practic I could practice so let me." The clinical record on 1/24/11 at 2:00 Assessment (MDS resident was cognium ambulating in the country of the assessment pedischarged from F5/12/10 ambulating using a rolling walk assistance), for a contraction of the assistance, for a contraction of the assistance and the assistance of the assistance and the as	interventions" and were both the 1/20/11 assessment date. after and DON indicated they lack of behavior documentation is lacking of an assessment of thosocial needs and behaviors repressive mood and crying. Indicated a roster of residents on tified Resident #3 as alert, le for interview. Interviewed on 1/24/11 at 2:30 indicated "The girls (CNA if to give me a chance to walk by don't. We have a walker and if belt safety device) but they used to go to therapy but my is able to do real good then but If the ce and I'm wobbly now. I wish me just here in the hall if they'd to fresident #3 was reviewed P.M. The Minimum Data Set in of 1/06/11 indicated the tively normal and the activity of corridor had not occurred during the provident with the sightly stooped posture, were and CGA (care giver distance of 90 to 100 feet.	F	272			
	to indicate an accu	is lacking in the medical record trate assessment of nursing tince needs had been instituted					

	10 0 11 12 13 14 15 15 15 15 15 15 15	OVAL DROUBERIOLIDE FERIOLIA	OVOLANI II TID	LE CONSTRUCTION	(X3) DATE S	IDVEV
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	
			B. WING			
		155361			•	5/2011
NAME OF F	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE 11 E ILLINOIS ST		
AMBER	MANOR CARE CENT	ER		ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	age 24	F 272	-		
	after the PT was di	scontinued.				
	CONFERENCE NO summary tool com update. It indicated by assistance) in the daily living) documentries was review from 8/1/10 to 9/01 documented to have times, requiring limits since 10/26/10 indicated of "Needs assistant and walking;" howe	the "RESIDENT FIRST DTES" on 9/1/10 was a pleted at the time of care plant d "ambulates with SBA (stand ne hall." The ADL (activity of centation by CNAs computer ed from the month preceding /10. The resident had been we ambulated in the hall three plant cated an ADL self care deficit ace or is dependent in transfer ever, the intervention of g or walking assistance had				
·	through 1/24/11 inc ambulated once w The CNA assignm	umentation from 12/01/10 dicated the resident had ith assistance in that interval. ent sheet in use on 1/25/11 is for the care of Resident #3.				
	On 1/25/11 at 10:3 of the resident requestion to ambulate belt and a rolling whesitant gait, requisitant gradually required occasional cueing. The resident was a 75 feet, sit to rest with the room. CNA # walked "if she tells"	O A.M. after being made aware uest, CNA #6 assisted the te in the corridor using a gait ralker. The resident initially had ring assistance to stabilize but stand by assistance with to correct stooped posture. The able to ambulate approximately when cued by the CNA and and then walk 75 feet back to 6 indicated the resident was us when she wants, but no ust when she asks."				

,	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		155361	B. WING_		01/2	5/2011
	ROVIDER OR SUPPLIER	ER	1	REET ADDRESS, CITY, STATE, ZIP CODE 801 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	age 25	F 272			
	been assessment	s lacking to indicate there had of the problem of the resident's and not being walked.				
	indicated the reside	0 P.M., the Director of Nursing ent was able to request he wanted to walk and had a make the request.				
	on 1/18/11 at 11:50 Data Set assessm indicated a severe assistance of staff	clinical record was reviewed 5 A.M. Her current Minimum ent (MDS) dated 1/3/11, cognitive impairment, for transfers and ambulation, otion impairment of upper and				
	indicated, "Res (re (complaint) R (righ (skin tear) to L (lef head-neuro (check	ed 1/12/11 at 3:00 P.M., sident) found on floor. C/O t) shoulder et elbow pain. ST t) elbow 1.7 x 2.2 cm. Bumped k) initiated WNL (within normal igns) 97.9 (temperature)-78 tions)"				
	indicated a skin tellinjury of bruising.	fated 1/12/11 at 3:00 P.M., ar of the left elbow and no Assessment included but was nplaint of pain of the right				
	A radiology report acute right humeru	dated 1/12/11, indicated an us fracture.				
	indicated,"X ray co	ed 1/12/11 at 10:00 P.M., ompleted MD notified. R (right) e to res (resident) body per MD				

PRINTED: 02/02/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	· .	(X3) DATE SU COMPLE	
		155361	B. WING	9		01/25	5/2011
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY 801 E ILLINOIS ST PETERSBURG, IN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORF	R'S PLAN OF CORREC RECTIVE ACTION SHO RENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	request." Documentation wa assessment after to Impairment Circum Intervention and an Assessment were The Skin Impairment and Intervention of bruises of the left extremities. No modocumented. The Other Skin Impairment and Intervention of bruises of the left extremities. No modocumented. The Other Skin Impairment and Intervention of the Skin Impairment and Intervention of the side had scattered were documented. On 1/19/11 from 9 Resident #41's care at 10:20 A.M., LPN with repositioning of the area(ranging from and the right torso areae to the mid to measurements were on 1/21/11 at 9:45 Nursing(DON) with Assistant Director the bruising of the measurements were form Other Skin Inhad been initiated upper extremity bruising bruising of the measurements were on the skin Inhad been initiated upper extremity bruising bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising of the measurements were on the skin Inhad been initiated upper extremity bruising the skin Inhad been initiated upper extremity brui	s lacking of a right arm he fall of 1/12/11 until a Skin histance, Assessment and an in Other Skin Impairment initiated on 1/18/11. ent Circumstance, Assessment ated 1/18/11, indicated, elbow and the right upper easurement of bruising was pairment Assessment dated left elbow and right arm and bruises. No measurements 1:00 A.M., to 2:05 P.M., he was observed. On 1/19/11 If I assisted Resident #41 of the right arm sling. Bruising he right outer arm from shoulder area to elbow yellow to purple discoloration) area approximately the axilla unk (purple discoloration). No	F 2	72			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 000252

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		155361	B. WING		01/25	/2011
	ROVIDER OR SUPPLIEF		80	EET ADDRESS, CITY, STATE, ZIP CODE D1 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	with small amoun area. The bruisin was measured as with two thirds of	t of purple at the antecubital g of the right side of the torso 20.5 cm length x 10.7 cm width the bruising a purple 1/3 a yellow discoloration.	F 272	F 311		
F 311 SS=D	A resident is give services to maint	EATMENT/SERVICES TO FAIN ADLS on the appropriate treatment and ain or improve his or her abilities graph (a)(1) of this section.	F 311	Resident #3 was evaluated I therapy and plan was as followed resident ambulates independ with a rolling walker but che to due to her confidence level history of falls. She require encouragement to walk	lowed dently looses not rel and s	
	by: Based on intervie observation, the tambulation service	ENT is not met as evidenced w, record review and acility failed to provide ses for 1 of 1 resident requesting a sample of 14. Resident #3	-	independently or ask for as when she so desires. No fur therapy intervention is indithis time. Resident was plarestorative program. Completion Date 2-16-20:	ther cated at iced on a	
	Findings include: The facility provided a roster of residents on 1/18/11 which identified Resident #3 as alert, oriented and reliable for interview.			All residents in the campus ability to ambulate have be screened by therapy to asse ambulation needs and assu	en ess	
	P.M. The resider staff) are suppose twice a day but the they got a belt (got don't get it done. I would don't get the practic tould practice set me. Maybe the	interviewed on 1/24/11 at 2:30 at indicated "The girls (CNA ed to give me a chance to walk ey don't. We have a walker and ait belt safety device) but they I used to go to therapy but my as able to do real good then but I stice and I'm wobbly now. I wish ome just here in the hall if they'd ey are afraid since I fell once ave out, but I should be OK with		met. Completion Date 2-16-20 Systemic change to include to complete quarterly screen residents with the ability to to assess ambulation needs assure needs met. Completion Date 2-16-20	e therapy ens for ambulate and	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	02/02/2011 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		155361	B. Wil	VG		01/25	5/2011
NAME OF P	ROVIDER OR SUPPLIER			ı	REET ADDRESS, CITY, STATE, ZIP CODE		
AMBER	MANOR CARE CENT	ER		ı	PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 311	Continued From pa	age 28	F	311			
	can do." The clinical record on 1/24/11 at 2:00 Assessment (MDS resident was cogni ambulating in the composition of the assessment pedischarged from P5/12/10 ambulating using a rolling walk assistance), for a composition of the composition	of Resident #3 was reviewed P.M. The Minimum Data Set) of 1/06/11 indicated the tively normal and the activity of corridor had not occurred during criod. Resident #3 had been physical therapy (PT) on g with slightly stooped posture, are and CGA (care giver distance of 90 to 100 feet. Is lacking in the record to ed program of walking en instituted after the PT was the "RESIDENT FIRST DTES" on 9/1/10 was a pleted at the time of care pland "ambulates with SBA (stand the hall." The ADL (activity of entation by CNAs computer ed from the month preceding 1/10. The resident had been we ambulated in the hall three nited assistance. The care plandicated an ADL self care deficit from the intervention of g or walking assistance had sumentation from 12/01/10 dicated the resident had ith assistance in that interval.			ED and /or designee to revi quarterly screens to assure completion and recommen are followed to met the resi ambulation needs with resu forwarded to the QA comments and quathereafter for review and fur suggestions/comments. Completion Date 2-16-201	dations dents lts being nittee arterly rther	

Event ID: JFNQ11

	OF DEFICIENCIES OF CORRECTION	iDENTIFICATION NUMBER:	A. BUI		G	COMPLE	
		155361	B. WIN	IG_		01/2	5/2011
NAME OF P	TER		80	EET ADDRESS, CITY, STATE, ZIP CODE 01 E ILLINOIS ST ETERSBURG, IN 47567			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 311	The CNA assignment provided direction. The restorative set of the resident recresident to ambulate the situant gait, required occasional cueing. The resident was 75 feet, sit to rest directed to a chair her room. CNA # walked "if she tells planned walking, j Documentation was been assessment ambulation status." On 1/25/11 at 12:2 indicated the residuance when sheen relied upon the restoration of the residuance when sheen relied upon the residuance when sheen relied upon the restoration of the residuance when sheen relied upon the restoration was sheen relied upon the residuance when sheen relied upon the residuance was sheet as the residuance was sheet a	age 29 sent sheet in use on 1/25/11 s for the care of Resident #3. ction was left blank. 30 A.M. after being made aware uest, CNA #6 assisted the ate in the corridor using a gait valker. The resident initially had iring assistance to stabilize but stand by assistance with to correct stooped posture. able to ambulate approximately when cued by the CNA and and then walk 75 feet back to 66 indicated the resident was as us when she wants, but no ust when she asks." as lacking to indicate there had of the problem of the resident's and not being walked. 20 P.M., the Director of Nursing lent was able to request she wanted to walk and had o make the request. een relied upon to make the	F	311			
F 314 SS=D	1	MENT/SVCS TO PRESSURE SORES	F	314			
	resident, the facility who enters the factories not develop individual's clinical	prehensive assessment of a y must ensure that a resident sility without pressure sores pressure sores unless the condition demonstrates that able; and a resident having		:	·		

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		455004	B. WIN				
		155361				01/2	5/2011
	PROVIDER OR SUPPLIER	ER		8	EET ADDRESS, CITY, STATE, ZIP CODE D1 E ILLINOIS ST ETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	pressure sores reciservices to promote prevent new sores This REQUIREMED by: Based on observative review, the facility for prevent the develop followed for 1 of 1 of facility-acquired prevent #14 Findings include: The clinical record on 1/18/11 at 3:10 were not limited to, deficiency, muscle behavioral disturbation (minimum data set indicated the follow summary score waindicated a severely was at risk for development of the prevent of	eives necessary treatment and healing, prevent infection and	F	314	Resident #14 no longer resident campus Completion Date 2-16-2011 All residents have the potential affected by the alleged deficing practice and through altercating processes and in servicing the campus will ensure measures prevent the development of processes. Completion Date 2-16-2011 Nursing staff have been in second pressure ulcer prevention nursing staff will complete a demonstration for removal of soiled brief on a resident in the Completion Date 2-16-2011	ial to be tent ions in e s to pressure erviced. Current return f a ped.	
	occur; resident alway bladder. Upon entrance into facility-provided ros	ays incontinent of bowel and			Systemic change annually ca will have brief vendor compl service on proper application removal of briefs. Completion Date 2-16-2011	lete in n and	
	9/15/10, indicated the	of daily living) care plan, dated ne following: "Needs bendent in: bed mobility,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		155361	B. WING _		01/2	5/2011
	ROVIDER OR SUPPLIER	ER	8	REET ADDRESS, CITY, STATE, ZIP CODE 01 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	"turn and reposition circulation" was lef as an intervention. A care plan, which "potential alteration 9/15/10. Intervention, but were let "turn and reposition. Nurses notes, date indicated the follow have a red sheared. A form titled "Other Assessment" was identified the areas admission; type: slength: 0.3; width (recent weekly mea indicated a length of "E." On 1/25/11 at 1 P.I Nursing) was intervent for depth indicated. A Pressure Ulcer L dated 12/27/10. Ti "Clinical conditions makes the likelihoo unavoidable includ resident immobility continuous urinary failure to thrive, hg mg/dl (milligrams pskin turgor and res	hygiene" The intervention of it, shifting weight to enhance to unchecked and not identified addressed the problem of it in skin integrity" was dated ons which were listed as an it blank and not included, were in." add 12/17/10, at 10 A.M. wing: "R (right) hip noted to diarea" The Skin Impairment dated 12/17/10. This form is as follows: Not present on the hearing; Location on right hip: 0.2; depth <0.2 (sic). The most surement was on 1/17/11 and of 1.2; width of 1.3 and depth of the wiewed. She indicated the "E"	F 314	DHS or designee will perform random audits of C.N.A. care assure following standards or prevent pressure ulcers on 3 residents 5x a week x one more a week x one month then we with results forwarded to the committee monthly x 6 month quarterly thereafter for review further suggestions/comment Completion Date 2-16-2011	e to f care to random onth 3x ekly QA chs and w and ts.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SI COMPLE	
		155361	B. WIN	G		01/2	5/2011
	ROVIDER OR SUPPLIER	ER		801	ET ADDRESS, CITY, STATE, ZIP CODE 1 E ILLINOIS ST TERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 314	following: "Apply son upper thigh dai On 1/19/11 at 9:30 interviewed. She is sore" on her right the resident off that The resident off that The resident's car 10 A.M., CNA #7 assisting the resident was rolled began rolling up the began rolling up the brief, until the rolled resident's skin. C the resident's left is she pulled the brief right hip, which was	dated 12/29/10, indicated the skin prep to water filled blister by x 7 days" O A.M., CNA #8 was indicated the resident "had a hip and they needed to keep at side. We was observed on 1/19/11. At leand CNA #8 were observed ent to check and change her sident on her back, they on both sides of the brief. The did to her right side. CNA #7 then he left side of the resident's led brief was close to the NA #7 then applied pressure to hip and with CNA #7's hand, lef out from under the resident's as planted on the bed. As the	F 3	114			
	the brief was stret creating a shearin observed to the research At 2 P.M., CNA #7 the resident by chagain, the CNAs observed at 10 A. the resident's brief to the resident's sign pressure to the re#7's hand, she puresident's right hip As the brief was resident was resident to the resident to the re#7's hand, she puresident to the re#7's hand, she puresident to the remainder to the re#7's hand, she puresident to the remainder to	If from underneath the resident, ched taught upon removal, g effect. A dressing was esident's right hip dated 1/19/11. If and CNA #8 again assisted ecking and changing her brief, assisted the resident as M. by rolling up the left side of f, until the rolled brief was close kin. CNA #7 then applied sident's left hip and with CNA led the brief out from under the p, which was planted on the bed, emoved from underneath the was stretched taught upon a shearing effect.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		155361	B. WIN	1G		01/2	5/2011
	ROVIDER OR SUPPLIER	≣R		8	REET ADDRESS, CITY, STATE, ZIP CODE 101 E ILLINOIS ST PETERSBURG, IN 47567		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 33	F	314			
	Nursing) was interv	O A.M., the DON (Director of iewed. She indicated the esident's right hip was a result be brief.					
	current, undated co procedure for "Wou Education Informat was not limited to, t as definedas a re with shear and fricti be classified by des	P.M., the DON provided a ppy of the facility's policy and and Staging and Identification ion." This policy included, but the following: "Pressure ulcers sult of pressure in combination ion. Pressure wounds should scribing the degree of tissue Stage II:may present as a			·		
	copy of the "other s form dated 12/29/10 following for the res admission; type: bl	P.M., the DON provided a kin impairment assessment" D. This form indicated the sident: "Not present on ister; location: left hip: length: m1/10/11 area was healed."					
	3.1-40(a)(2)						
						·	